Commentary

Ruminations of a Teaching Surgeon

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I am highly honored and deeply grateful to be the recipient of this singular honor from the California Medical Association.* I would like to take a rather lighthearted approach to reviewing my world of medical education.

Laroff's credo says:

"It is not so important to be serious as it is to be serious about what's important."

One of the strong memories in my career was coming to California and Stanford University in 1963 as Chairman of the Department of Surgery. My vision over the years had been that except for the captain of an ocean-going liner, the last reigning monarch was the Chairman of a Department of Surgery. "Power, power at last," I thought to myself. So as an early initiative, I phoned the emergency department, the intensive care unit, the recovery room, and various areas to check on their facilities and readiness. I called the operating room and got the doctors' dressing room orderly. "Doctors' dressing room," said he. I said, "I would like to inquire about locker facilities for surgeons." "Well," he responded, "we have some open half singles for students and residents, some slightly rusty back lockers for attendings and visitors, and for the fat-assed professors, we have some new combination, secured, full length lockers." "Do you know who this is?" I questioned. "Nope," was his response. "This is Professor Chase, new Chairman of the Department of Surgery," said I authoritatively. "Do you know who this is?" he inquired. "Well, no," I answered. "Well, goodbye, fat ass," he retorted as the phone clicked off.

Memories

I would like to go back 47 years to 1943 when I started in the study of medicine. It was, in Dickens's words, ". . . the best of times and the worst of times," before ball point pens, pantyhose, and credit cards. Before hair dryers, second opinions, and touch-tone telephones. We didn't dare say condom out loud but had no fear of referring to hearts as young and gay. It was an age when Madonna was a statue at the local Catholic church, third-party carriers helped with your luggage, and marketing was something you did with a basket.

It was an era when TLC didn't mean thin layer chromatography and HMO was Haley's famous laxative. MR meant mister and medically indigent adults were not MIAs. MIA had the jarring and depressing meaning that it had again during the Gulf war. APCs were not armored personnel carriers. In those days physicians knew who Osler and Halsted were and fear of malpractice was not a driving force in medical decisions. Podiatrists did podiatry, general surgeons were general, and the only treatment in gastroenterology was some variation of the Sippy diet, whereas today's fiberoptic endoscopy presents endless opportunities to look into oneself. Less than a radical mastectomy would have been malpractice—if there had been malpractice. A hand-held calculator was a slide rule and AIDS identified people who helped nurses or wore pink frocks. Closets were not for coming out of. Gallbladders were removed by incision and dissection.

It was before "thank you" was said by flashing lights at the toll booth and when "have a nice day" meant have a nice day. Affirmative action was a vote at the town meeting.

It was before MRI, RVS, CME, and PPO. Oncology wasn't even a word.

We surgeons didn't know we were in a noncognitive specialty. There were no lasers, surgical staples, vascular grafts, or joint prostheses. Digital subtraction meant finger amputation, lithotripsy was a technique for jumping rope, and ultrasound came from jukeboxes.

A hospital day cost $65, and an appendectomy brought $125 maximum. Free care was freely given and Robin Hood ordered the behavior of administrators. Now it's rob the rich and pay the lawyers. It now costs more to go to the hospital than it did then to go to medical school. We didn't call firing people down-sizing or being de-selected, outplaced, or non-positively terminated, and a set of objectives was not a paradigm. Quality assurance was the wear guarantee that came with interwoven socks.

I would have thought a suppressor oncogene was an auto part or a radio tube. There were no contact lenses, throw-away syringes, cyclosporins, monoclonal antibodies, or re-certifications. A chromosomal short arm could have been misinterpreted by us Army docs.

Come and gone in my years have been—Wangensteen's gastric freezing, Smithwick's total sympathectomy, Gillies' tubed pedical flap, and a whole host of procedures now dealt with medically or radiologically.

In our days kids played doctor—now they play specialist and their little doctors' kits come with a malpractice insurance policy. In the ER they used to take your vital signs—now they take your Blue Cross number.

We were grossly deficient in what we could do physically for our patients—no open heart surgery, no endoscopic surgery, no microsurgery, no transplant surgery, but medical care meant caring for the patient. In many ways—the best of times.

What has continued as best for me is the privilege of teaching. There is real pleasure in watching and helping students develop from freshmen who think the cesarean section is a district in Rome to seniors who understand the details of genetic recombinant DNA therapy far better than I.

*Dr Chase received the 1991 Golden Apple Award, presented by the California Medical Association to recognize exceptional physicians who have made a lifelong commitment to teaching.

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It has been fun to observe the cyclic changes in medical school related to

- Grading versus pass/fail
- Core curriculum versus electives
- Honors versus no honors
- The early introduction to clinical medicine
- Organ systems approaches
- Problem-oriented learning
- Thesis requirements
- Attitudes towards the National Board Examinations

There are lots of experimental curricula as at Case Western Reserve, McMaster University, Miami, and Harvard with their "New Pathway." Our generation can be characterized as one offering French in kindergarten and remedial English in college. In academic medicine we see evidence of this when reading histories. Here are some entertaining chart entries:

This gentleman urinates around the clock every four hours.

A 54-year-old woman arrived with abdominal distress—she has constipation on the one hand and diarrhea on the other.

This 30-year-old male is married—no other serious illness.

Or a prescription I saw that read, "Tenactin suppositories, dispense 24 (such) Sig: Insert one every four hours until exhausted."

What incredible satisfaction I have had in watching the unfolding of the careers of students and trainees. Recommending them for the next step in their careers is generally one of the pleasures. Yet, in today's era of freedom of information, letters are available to the student or trainee. This has led to what Lederer calls the "mangled modifier" strategy for letters of recommendation. Watch for varying interpretations in letters describing students. For example:

For the lazy student

"You'll be lucky to get Harvey to work for you," or

"I can't recommend him too highly."

For the person in trouble with the law

"He is a man with many convictions."

For the heavy drinker

"I spent many happy hours with Hubert."

Participating as a CME instructor is always profitable educationally, since one learns from the participants. Although ours has been identified as a learned profession, its proudest attribute is that it is a *learning* profession.

As a teacher, do I have concerns? Of course I do. I have noted with some alarm the drop in the number of applications to medical school—about 31% over the last decade with an applicant-to-billet ratio going from 3.5 applications to one position in 1950 to 1.6 to one in 1990. Fortunately, this year's application numbers have started to rise. Disturbing, however, were data from the American Association of Medical Colleges survey of students who took the MCAT, then did not apply to medical school. Of these, a half had chosen alternative careers, and 30% of these were advised against medicine by physicians predominantly from the older generation.

I am concerned at the growing average indebtedness of our graduates. In 1989 the average debt for medical school graduates was $42,374—nearly twice what it was in 1987.

I worry that medical schools have become more dependent upon faculty-earned practice funds. In 1971 practice funds furnished 12% of total school revenues, whereas in 1990, 43% of revenues came from faculty practice earnings.

The Future

In the years ahead, our profession generally has enormous new problems to solve. A simple listing of a few of the issues might include

- The continuing struggle to meet the health care needs of our citizens versus the reality of budget constraints and deficit reduction
- Over 30% of babies admitted to inner-city intensive care units are born to "crack" abusing mothers, and 2% or 3% are positive for the human immunodeficiency virus (HIV)
- An estimated 1 million people in the United States are HIV-positive
- 37 health care workers are thought to have contracted HIV infections on the job, largely from needle sticks
- 14% of medical schools report medical students or residents who are HIV-positive
- 40 surgeons and 144 dentists are known to have the acquired immunodeficiency syndrome, and the Centers for Disease Control estimates at least ten times this many are HIV-positive
- Old diseases such as measles are reappearing—13,000 cases in the United States in 1989
- The whole issue of positive euthanasia
- The problem of physician participation in executions for capital punishment
- Sex between physicians and patients, said to have an incidence of 5% to 10% among psychiatrists
- The need for guidelines on ethics of various drug house gifts and favors
- The growing evidence of fraudulent research

And the list goes on.

Above all, we must not let problems, challenges, and advances cloud those wonderful attributes of our profession and its activities that are changeless. Quantitatively, most clinical medicine is straightforward. It is our privilege to help most patients because they have simple curable disorders, and it is equally important that we offer effective reassurance to the one-third to one-half of patients coming to us who have no physical or biomedical ailment. In academia we are inclined to search for zebras.

Responsibility at a distance as in "managed care" will never substitute for a physician's responsibility for his or her patient. I find that the apparent ease with which a problem may be solved is directly proportional to one's distance from the problem. Since a physician knows more than anyone else about his or her patient, he or she is, by definition, captain of the health care team.

Next to being shot at and missed, nothing is really as satisfactory professionally as a good surgical outcome recognized by both the patient and the surgeon. A poor result makes one wish that the shot had not missed.

Despite the fact that we may all become salaried employees with rules based on cost, faced with ethical issues of monumental proportions because of emerging technologies, and despite the specter of malpractice litigation and diminishing public respect, as well as demands of society through third-party carriers and government, despite all of these, the most precious gift of all—the relationship between physician and patient—remains and always will remain in our hands.